Medical History

It is very important that I know your medical and dental history. An accurate and current history is essential to provide you with the safest, most appropriate treatment indicated for your specific situation. If there are any questions which you do not understand, just circle the question and the doctor will clarify that item at the exam. This information is strictly confidential and will not be released unless your consent is given in writing.
Thank you for taking the time to completely and accurately answer this questionnaire.

Your estimated current physical health is: ❑Good ❑Fair ❑Poor Are you currently under the care of any physician? ❑Yes ❑No

Physician's name: _____ City/State: _____ Phone No.: _____

When did you last consult a physician? _____ Reason: _____

Have you been a patient in a hospital in the past 6 years? ❑Yes ❑No Reason: _____

Have you ever had any serious illness or operations? ❑Yes ❑No Describe: _____

_____

Are you taking any medications, or pills either prescription or over-the-counter? Please list, _____

_____

Do you have, or have you had any of the following?

1. Hip replacement, Artificial Joints ..... ❑Yes ❑No
   a. If yes, Location: _____ Type: _____
   b. How long after transplant: _____
   c. Any problems associated with the joint ..... ❑Yes ❑No
   Ex.: replacement, infections, hematoma
2. Immunosuppressed by either a drug of a disease.. ❑Yes ❑No
   Ex.: Systematic Lupus, Chemotherapy, Aplastic Anemia, HIV
3. Heart Disease
   a. Need to be pre-medicated with antibiotics before dental treatment ..... ❑Yes ❑No
   Reason: _____
   b. Artificial valve Replacement ..... ❑Yes ❑No
   c. History of Bacterial Endocarditis ..... ❑Yes ❑No
   d. Congenital Heart Disease ..... ❑Yes ❑No
   Ex.:
   - unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits
   - a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure
   - any repaired congenital heart defect with residual defect at the site adjacent to the site of a prosthetic patch or a prosthetic device.

   e. Cardiac transplant that develops a problem in a heart valve ..... ❑Yes ❑No
   f. High Blood Pressure ..... ❑Yes ❑No
   g. Myocardial Infection, Heart Attack ..... ❑Yes ❑No
   h. Pacemaker, Heart Surgery ..... ❑Yes ❑No
   i. Stroke ..... ❑Yes ❑No
4. Blood Disorder:
   a. Anemia, Bleeding Problem ..... ❑Yes ❑No
   b. Hemophilia ..... ❑Yes ❑No
   c. Blood Transfusion ..... ❑Yes ❑No
5. Arthritis ..... ❑Yes ❑No
6. Seizures, Epilepsy, Fainting ..... ❑Yes ❑No
7. Tumor History, Cancer ..... ❑Yes ❑No
8. Chemotherapy, Radiation Treatment ..... ❑Yes ❑No
9. Sinus Trouble/Infections ..... ❑Yes ❑No
10. Psychiatric Treatment ..... ❑Yes ❑No
11. Glaucoma/Cataracts/Loss of Sight ..... ❑Yes ❑No
12. Earaches, Ringing in Ears, Loss of Hearing ..... ❑Yes ❑No
13. Osteoporosis/Osteopia
    a. Have you ever taken oral bisphosphonate such as (Actonel, Fosamax, Boniva, Shield, Dedronel)... ❑Yes ❑No
14. Have you ever taken IV bisphosphonate such as (Zomete, Aredic, Benefos) ..... ❑Yes ❑No
15. Thyroid Disease: (Hypothyroid, Hyperthyroid) .. ❑Yes ❑No
16. Diabetes, If yes, date diagnosed _____ ❑Yes ❑No
17. Kidney Disease ..... ❑Yes ❑No
18. Ulcers ..... ❑Yes ❑No
19. Hepatitis, Liver Disease, Jaundice ..... ❑Yes ❑No
20. Venereal Disease, Syphilis, Gonorrhea, Herpes. ❑Yes ❑No
21. HIV+, A.R.C., A.I.D.S. ..... ❑Yes ❑No
22. Asthma, Emphysema, Bronchitis ..... ❑Yes ❑No
23. Tuberculosis ..... ❑Yes ❑No
24. Chemical Dependency, Alcohol, Drug use ..... ❑Yes ❑No
25. Cigarette, Snuff ..... ❑Yes ❑No
    a. Duration _____ Quantity _____
24. Have you taken within the last 12 months:
    a. Cortisone, Steroids ..... ❑Yes ❑No
    b. Anticoagulants, Blood Thinners ..... ❑Yes ❑No
25. Allergies (Please circle)
    a. Penicillin, Erythromycin, Cephalosporins ..... ❑Yes ❑No
    b. Tetracycline ..... ❑Yes ❑No
    c. Other Antibiotics ..... ❑Yes ❑No
    d. Codeine ..... ❑Yes ❑No
    e. Aspirin ..... ❑Yes ❑No
    f. Sleeping Pills ..... ❑Yes ❑No
    g. Dental Anesthetics ..... ❑Yes ❑No
    h. Other ..... ❑Yes ❑No

Women

1. Regular Menstrual Cycle ..... ❑Yes ❑No
2. Are You Pregnant ..... ❑Yes ❑No
3. Are You Taking Birth Control Medication ..... ❑Yes ❑No
4. Are You Taking Hormone Supplements ..... ❑Yes ❑No

(Continued on back)

Dental History

Present Dental Complaint? _____

_____

Have you experienced any unfavorable reaction to previous dental treatment? Describe _____

_____

Who is your regular dentist? _____ For how long? _____

When did you last have any dental work? _____ What was done? _____

When were your teeth last cleaned? _____ How long before that? _____

How often do you brush your teeth? _____ Floss? _____

Are you using any other dental cleaning aids? If so, what? _____

Are you experiencing any pain in your mouth. Where? _____ ❑ Yes ❑ No

Are your teeth sensitive..... ❑ Yes ❑ No

Are any of your teeth loose..... ❑ Yes ❑ No

Do you have any unpleasant taste or odor in your mouth..... ❑ Yes ❑ No

Do your gums bleed? If yes, when? _____ ❑ Yes ❑ No

Do you grind or clench your teeth..... ❑ Yes ❑ No

Have you noticed increasing spaces between teeth? If yes, when? _____ ❑ Yes ❑ No

Are your gums receding..... ❑ Yes ❑ No

Are you missing teeth? Reasons: Cavities ( ) Gum Disease ( ) Trauma ( )..... ❑ Yes ❑ No

Were missing teeth replaced..... ❑ Yes ❑ No

Are you satisfied with the appearance of your teeth..... ❑ Yes ❑ No

Has periodontal disease been found in your mouth before? If yes, when? _____ ❑ Yes ❑ No

Have you ever had periodontal treatment? If yes, when? _____ ❑ Yes ❑ No

Have you ever had orthodontic treatment (braces)..... ❑ Yes ❑ No

Are you seeing a doctor for DENTAL IMPLANTS..... ❑ Yes ❑ No

Do you presently wear full dentures? Upper ( ) Lower ( )..... ❑ Yes ❑ No

Do you presently wear removable partial dentures? Upper ( ) Lower ( )..... ❑ Yes ❑ No

Are you interested in replacing your denture or partial with implants..... ❑ Yes ❑ No

Why are you dissatisfied with your present appliances:

____ The inconvenience ____ The appearance ____ Inability to chew ____ Painful ____ Other

Do you presently have missing teeth that have not been replaced..... ❑ Yes ❑ No

Treatment Authorization and Informed Consent

I consent to examination as necessary or desirable to care of the registered patient, for the diagnosis of dental disease, deformity, or treatment or dental emergency. The procedures may include radiographs, models, photographs and intra-oral exam. In case of a dental emergency, I consent to emergency treatment as deemed necessary by the doctor, understanding that procedures will be explained in advance. I have read and completed this questionnaire to the best of my knowledge and agree to the above policy.

_____ _____

Patient, Parent or Legal Guardian Date Periodontist Date